# Application for internal review

## Use this form if you are a CTP Care client and you would like to request an internal review of a decision made by us.

## ****Client details****

|  |  |
| --- | --- |
| **Name** | **Date of accident** |
|   |   |
| **CTP claim number** | **Date of birth** |
|   |   |
| **Contact person (if different)** | **Contact phone number** |
|   |   |
| **Street address** |
|   |
| **Suburb** | **State** | **Postcode** |
|   |   |   |
| **Email address** |
|   |

## Decisions for internal review

|  |
| --- |
| **What is the date of the Notice of Decision(s) that you would like to have reviewed?** |
|   |
| **When did you receive the decision(s)?** |
|   |
| **What decision(s) do you want reviewed? (e.g. my ongoing physio has been declined)** |
|   |
| **Why do you believe the decision should be changed? (e.g. I am still in pain)** |
|   |
| **What would you like to be the outcome of the review? (e.g. my physio to continue)** |
|   |
| **Do you want to provide any further information? If so, please write the details below or attach any additional documents you would like considered as part of the internal review.** |
|   |
| **Name** |
|   |
| **Date** |
|   |

Please send completed form to:

|  |  |
| --- | --- |
|  | Customer Resolution TeamCTP CareEmail: feedback.ctpcare@icare.nsw.gov.au GPO Box 4052, Sydney, NSW 2001**General Phone Enquiries: 1300 738 586** |